

DEPARTMENT OF COMMERCE

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

26398

FILLED AT St. Louis

State File No. \_\_\_\_\_

Registration District No. 840

Primary Registration District No. 6102

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

- (a) County Stoddard  
(b) City or town Carroll Creek  
(c) Name of hospital or institution: \_\_\_\_\_  
(If outside city or town limits, write "RURAL" and name of township)

(If not in hospital or institution, write street number or location)

- (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)

In this community Three Weeks  
years, months or days

8. (a) PRINT FULL NAME MISSOURI ELLEN ROBINSON

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Walter Robinson 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Feb 9 1869  
(Month) (Day) (Year)

8. AGE: Years 12 Months 2 Days 3 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Bullitt Co Ky  
(City, town, or county) (State or foreign country)

10. Usual occupation Housework

11. Industry or business Own Home

- MOTHER FATHER { 12. Name Gleason Burton  
13. Birthplace Ky  
14. Maiden name Anna Myers  
15. Birthplace N.C.  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. H. M. Lowley  
(b) Address Fish Mo.

17. (a) Burial (b) Date thereof 7 13 41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hope Cemetery

18. (a) Signature of funeral director Raymond

(b) Address Support, Ark.

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Mo (b) County Butler  
(c) City or town Fish  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) If foreign born, how long in U. S. A.? 1 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 12  
year 1941 hour 2 minute AM

21. I hereby certify that I attended the deceased from Mar 11 1941 to Mar 17 1941

that I last saw him alive on Mar 17 1941

and that death occurred on the date and hour stated above

Immediate cause of death Heart Failure

Due to Blunt Force Injury

Due to 1210

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature R. E. Lowley (M. D. or other) \_\_\_\_\_

Address Fish Mo. Date signed 7-13-41

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Office No. 2,

District File Number 841-1067

Date Filed 8-12-41

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by \_\_\_\_\_

\_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_  
working under my personal supervision.

Signed \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 26398

Registration District No. 840

Primary Registration District No. 6102

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Stoddard  
(b) City or town Jack Creek Twp  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME Missouri E. Robinson  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced W  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased \_\_\_\_\_  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 12  
year 194 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_;  
that I last saw him/her alive on \_\_\_\_\_ 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_ Duration \_\_\_\_\_

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

(b) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

(Specify type of place)  
While at work? \_\_\_\_\_ (c) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

